# Anthem® Dental Blue® Application

Please print – complete in blue or black ink only.
**Important: To be eligible to apply for this coverage you must be less than 65 years of age.**

Anthem. Health. Join In.

## Section A–Applicant Information

*This information is used for internal purposes only and will not be disclosed.

| Last Name | First Name | MI | Social Security Number* |
|---|---|---|---|
| | | | |

| Home Address (street and P.O. Box if applicable) | City | State | ZIP |
|---|---|---|---|
| | | | |

| County | Gender M F | Date of Birth / / | Age | Phone Number ( ) | E-mail (not shared with any third party) |
|---|---|---|---|---|---|
| | | | | | |

If you currently have medical, dental or life coverage through Anthem Blue Cross and Blue Shield: *Identification No.*

## Section B–Dental Coverage Information

**Effective date requested:** If your application is approved, your coverage can start on any day of the month after the date we receive your application. Please choose the date you would like your coverage to start: _____/_____/_____ (MM/DD/YY).

☐ **Dental Blue® Basic 100** ☐ **Dental Blue® Essential 100** ☐ **Dental Blue® Essential 200**

## Section C–Spouse/Domestic Partner & Child Dependents to be Covered Information (All fields required, attach separate sheet if needed)

Dependent information must be completed for all additional dependents (if any) to be covered. List all dependents beginning with the eldest.

| First, MI (last name, if different) | Relationship to Applicant | Social Security Number* | Gender | Age | Date of Birth |
|---|---|---|---|---|---|
| | Spouse/ Domestic Partner | | M F | | / / |
| | [Child] | | M F | | / / |
| | [Child] | | M F | | / / |
| | [Child] | | M F | | / / |

## Section D–Billing Information

Frequency (select one)
☐ Monthly ☐ Quarterly
☐ Semi-annually ☐ Annually

**Initial Premium** ☐ Bank Draft (see below) ☐ Credit Card (see below) ☐ Premium check enclosed (make check payable to ***Anthem Blue Cross and Blue Shield***)

**Initial premium amount**: $ _____

Method (select one)

☐ **HOME –** Bills will be to the address above unless a different address is specified below:

Name Address (street and PO Box if applicable) City State ZIP

☐ **AUTOMATIC BANK DRAFT** – Premium is deducted on the same day of the month as your effective date; ***you must attach a blank, voided check.***

*If selecting Automatic Bank Draft: I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. This authorization is in effect until I notify Anthem in writing that I no longer desire this service, allowing Anthem reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals at their discretion.*

Account holder's name (please print) Account holder's signature

X X

☐ **CREDIT CARD** – A credit card can be used only for this initial premium payment. If your application is accepted, you will be billed directly for future payments or you may request a Premium Payment form to change to automatic bank withdrawal. Your credit card will not be charged unless you are approved for coverage.

Cardholder's Name (as shown on the credit card) and Address:

X

*I authorize Anthem Blue Cross and Blue Shield to charge the credit card indicated for the amount specified in **Initial Premium** (above). If applicant is using the credit card of another cardholder: By signing this form, applicant represents and warrants that he/she has the cardholder's authorization to use this card and, if not, that he/she will take full responsibility for this payment and any charges accruing to it.*

Type of Credit Card: ☐VISA ☐MasterCard ☐Discover ☐Amex Applicant's Signature

Credit Card Number _____ Expiration Date (month/year): _____ / _____

| Signature of Applicant *(if age 18 or older, or Custodial Parent's or Guardian's signature if applicant is under age 18)* | Date |
|---|---|
| | |

| Signature of Spouse or Domestic Partner *(if enrolling)* | Date | Signature of Dependent/Child *(18 or over, if enrolling)* | Date |
|---|---|---|---|
| | | | |

Life and Disability products underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association.
Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWi"), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare"), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

| **Section E–Agent Certification** | | | |
|---|---|---|---|
| Agent Signature<br>**x** | | | Date |
| Agent Name (please print)<br>null null | Agent Street Address/Suite No./Personal Mail Box (PMB)No. | | |
| Agent ID No. | City/State/Zip | County Code | Area |
| Agent Phone No. | Agent Fax No. | Agent Email Address | |
| General Agent (if applicable) (please print) | | General Agent code (if applicable) | |